

NAME: _____ SS#: _____ DATE of BIRTH: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE(home): _____ CELL: _____ EMAIL: _____

EMERGENCY CONTACT: _____ REALTIONSHIP TO YOU: _____ PHONE: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NO (PLEASE CIRCLE) DATE: _____

PLEASE LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING:

- | | | | |
|----------|----------|-----------|-----------|
| 1. _____ | 5. _____ | 9. _____ | 13. _____ |
| 2. _____ | 6. _____ | 10. _____ | 14. _____ |
| 3. _____ | 7. _____ | 11. _____ | 15. _____ |
| 4. _____ | 8. _____ | 12. _____ | 16. _____ |

<u>DRUG ALLERGIES:</u>	<u>YES / NO</u>	<u>If yes, what happens?</u>
Latex, Adhesive Tape	_____	_____
Penicillin	_____	_____
Other Antibiotics	_____	_____
Empirim, Tylenol	_____	_____
Aspirin, Advil, Aleve, or Motrin	_____	_____
Celebrex	_____	_____
Other Pain Remedies	_____	_____
Morphine	_____	_____
Codeine	_____	_____
Demerol	_____	_____
Other Narcotics	_____	_____
OTHER:	_____	_____

FAMILY HISTORY:

List the relationship to you of family members who have had:

- HEART DISEASE _____
- HIGH BLOOD PRESSURE _____
- STROKE _____
- CANCER _____
- GLAUCOMA _____
- DIABETES _____
- EPIELSY/CONVULSIONS _____
- BLEEDING DISORDER _____
- KIDNEY DISEASE _____
- THYROID DISEASE _____
- MENTAL ILLNESS _____
- OSTEOPOROSIS _____
- BIRTH DEFECTS _____

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

- | | | | |
|---------------------------|-------------------------------|----------------------------|-----------------------|
| High Blood Pressure _____ | Lactose Intolerance _____ | Heart Attack _____ | Scarlet Fever _____ |
| Shortness of breath _____ | Gallbladder Disease _____ | Poor Circulation _____ | Chronic Rashes _____ |
| Any Heart Condition _____ | Prostate Disease _____ | Liver Disease _____ | Rheumatic Fever _____ |
| Chest pain _____ | Phlebitis _____ | Lung Disease _____ | Mumps _____ |
| Dizziness/Fainting _____ | Anemia _____ | Nerve Disorder _____ | Rubella _____ |
| Vascular Disease _____ | Diabetes _____ | Tuberculosis _____ | Polio _____ |
| Headache _____ | Gout _____ | Thyroid Problem _____ | Diphtheria _____ |
| Asthma _____ | Sciatica _____ | Pneumonia _____ | Hepatitis _____ |
| Cancer _____ | Hearing/Ear Disorder _____ | Psychiatric Disorder _____ | Tetanus _____ |
| Epilepsy _____ | Unexplained Weight Loss _____ | GI Disorder _____ | Measles _____ |
| Ulcer _____ | Depression _____ | Allergies/Hay fever _____ | Bronchitis _____ |

HAVE YOU EVER HAD SURGERY OR BEEN HOSPITALIZED FOR 24 HOURS? YES / NO (PLEASE CIRCLE)

<u>LIST SURGERY/HOSPITALAZATION:</u>	<u>ON DATE:</u>	<u>COMPLICATIONS:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS: (PLEASE CIRCLE BELOW WHICH APPLY)

- | | | | | |
|--|----------------------------|---------------------------|---------------------|-------------------------|
| Do you smoke now? _____ | Alcoholic beverages? _____ | Recreational Drugs? _____ | Caffeine Use: _____ | Special Diet: _____ |
| How long? _____ | None | None | None | _____ |
| Packs/day _____ | Rarely | Rarely | Rarely | Exercise Routine: _____ |
| Are you interested in stopping? _____ | Moderately | Moderately | Moderately | _____ |
| Have you ever smoked? _____ | Daily | Daily | Daily | Sleep Disorder: _____ |
| If yes, how long since you quit? _____ | Quit | Quit | Quit | _____ |